PRE-HOSPITAL CARE REPORT REQUEST FORM

Gilbert Fire & Rescue Department | 85 E Civic Center Drive, Gilbert, AZ 85296 | Phone 480-503-6300 | GFDrecordsrequest@gilbertaz.gov

REQUESTOR INFORMATION

NAME:		PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:

RELATIONSHIP

- ◯ Patient/Self
- ◯ Parent/Guardian
- ◯ Representative/Executor or Administrator of Estate
- ◯ Law Enforcement (see below)
- ◯ Subpoena
- ◯ Law Firm
- ◯ Organ Donor Network
- ◯ OTHER *(Indicate relationship to Patient):*

INCIDENT INFORMATION

DATE OF INCIDENT:	**TIME:**
EMS INCIDENT # *(IF KNOWN)*	INCIDENT LOCATION (Address or cross streets)

PATIENT INFORMATION

NAME:	**DOB:**

REQUIRED PROOF AND/OR DOCUMENTS NEEDED TO OBTAIN REPORT REQUESTED

Patient/Self	▪ A notarized authorization for release **OR** photo ID
Parent/Guardian	▪ Copy of Birth/Death Certificate **OR** Court document showing custody/guardians
Requestor is NOT Patient	▪ Notarized Authorization from Patient **OR** Notarized Power of Attorney **OR** Proof of court appointment as executor or administrator of patient's estate **OR** if patient deceased, letters of testamentary or letters of administration and copy of death certificate.

DELIVERY METHOD OF REPORT REQUESTED

- ◯ Pick up at Gilbert Fire & Rescue Dept. 85 E Civic Center Drive, Gilbert AZ
- ◯ USPS Address: _____
- ◯ Email to ☐ Encrypted or ☐ Not Encrypted: _____

LAW ENFORCEMENT REQUEST ONLY ---- Reason for Request

- ◯ To locate or Identify a suspect, fugitive, material witness, or a missing person
- ◯ Need information about victim of a crime
- ◯ Individual appears to have died as a result of criminal conduct
- ◯ To avert a serious threat to the health or safety of the patient or someone else

All other requests outside of above criteria would require patient consent or judge signed subpoena

DECEASED PATIENT MEDICAL RECORD CRITERIA (REFERENCE ARS §12-2294(D))

Check box identifying relationship with patient:

- ◯ Spouse (unless legally separated at time of death)
- ◯ Adult child of deceased patient
- ◯ Parent of deceased patient
- ◯ Adult brother or sister of deceased patient
- ◯ Guardian or Conservator of the deceased patient
- ◯ Acting trustee of a trust created by the deceased patient

REQUESTS SUBMITTED WITH ALL REQUIRED DOCUMENTATION WILL BE PROCESSED USUALLY WITHIN 10 BUSINESS DAYS

SIGNATURE OF PATIENT OR PARENT/GUARDIAN OR REPRESENTATIVE do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

_____ _____ _____

Signed Print Name Date

SIGNATURE NOTARIZATION

I, (Name of Notary) , _____ do hereby certify that _____ (Name of requesting party)

Personally appeared before me and affirmed the contents of the above request. In witness whereof, I have signed and affixed my official seal this _____day of _____Year _____Notary Public in and for the County of _____, State of ____.My comm. expires on_____.